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The Surgical Treatment of Portal Hypertension

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SUMMARY

Portacaval shunt operations were done in 15 of 18 patients who were treated surgically for portal hypertension. In eight cases the shunt was established by splenorenal anastomosis; in seven by anastomosis of the portal vein to the side of the inferior vena cava. Of the eight patients with splenorenal shunt, two are well, four are considered improved, and two have died. Of the seven in whom the portal vein was joined to the vena cava, two are improved, one is unimproved, and four have died.

BLAKEMORE and Lord¹ and Whipple¹⁷ stimulated renewed interest in the problem of portal hypertension with their reports in 1945 of successful venous anastomosis which permitted portal blood to flow directly into the systemic circulation, bypassing obstructions in the usual portal pathway. Their original technique of performing the venous anastomosis with vitallium tubes has been supplanted by the method of direct suture anastomosis. The principle of the venous shunt, however, remains as one of the most effective methods of relieving portal hypertension. Von Eck⁵ in 1877 performed the first portacaval anastomosis in dogs, using a

side-to-side technique that has become known as the Eck fistula. Whipple¹⁸ has observed dogs with Eck fistulas for as long as eight years. These animals had occasional episodes which were attributed to disturbed protein metabolism, but they generally maintained a satisfactory state of health. Prior to the reports of Blakemore, Lord and Whipple, isolated attempts had been made to apply this principle of shunting blood directly into the systemic circulation in cases of portal hypertension. Minor branches of the portal and systemic system were usually employed and thrombosis at the site of anastomosis invariably accounted for the failure of the procedure.

Blood carried into the portal area passes through two capillary systems before returning to the heart. It passes through a set of capillaries in the viscera, from which it is collected into the veins of the portal system and is then carried to the second set of capillaries in the liver. From here, it is returned to the heart by way of the inferior vena cava. Any condition which inhibits the free flow of blood in the portal system into the inferior vena cava usually increases the pressure of the blood in all or a part of the portal system.

Patients with an elevation of the venous pressure in the portal system may be divided into two main groups as suggested by Whipple: Group I, those having an intrahepatic portal block; and group II, those having an extrahepatic block.

INTRAHEPATIC BLOCK

Intrahepatic block is usually associated with cirrhosis of the liver. The actual cause of portal hypertension in cirrhosis has not been clearly demonstrated. It has been suggested that intrahepatic fibrosis narrows the lumen of the portal vein

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EDITORIAL

War and Doctors

War in Korea has pointed up the need for additional fighting men and, with them, additional medical officers. Doctors are more in demand than are members of other professions and groups, and many of them are today asking when their turns may come and, if so, by what means will they be called.

In World War II the country was plunged into all-out war on December 7, 1941. In the present conflict the United States is acting as the standard-bearer for the United Nations, presumably the spearhead force for an international police contingent expected to encompass elements from the armed forces of a score of countries. In these circumstances there is bound to be a totally different philosophy abroad than in the late days of 1941 and the months immediately following.

Added to the philosophical consideration is the fact that today there are many more physicians serving in reserve status with the armed forces than there were prior to Pearl Harbor. Many more are subject to call and are considered as qualified veterans.

In the circumstances many doctors are today asking if there is not some equitable order of going, so that those who served their country in the last war and are just now regaining their professional and economic status after that sacrifice may not be immediately called upon for a further period of service. Is there not, they ask, some logical means of spreading the burden among all of us? This question has led to the formation of groups in some states to provide an orderly system of medical officer recruitment. It has brought forth an official declaration by the A.M.A. House of Delegates and similar declarations by medical groups in the states

and counties. Most recently it has resulted in the introduction of H.R. 9311 in Congress (the author: Representative Saylor of Pennsylvania) to call for an order of priorities in the recruiting and assignment of medical officers for the three branches of the armed forces.

The consensus in all quarters seems to be completely in accord with the resolution adopted by the House of Delegates of the A.M.A., which provides essentially: The priority for recruiting medical officers shall call for (1) those recent graduates who received part or all of their medical education at federal expense and who have not completed their required tour of duty *and* those who furnished their own funds for their medical education but were deferred from active duty because of their student status; (2) other physicians who did not serve in World War II, and (3) those physicians who served the least in World War II.

These priorities, with conditions of age, infirmity or absolute irreplaceability considered, appear to be pretty generally accepted in medical circles throughout the country. The logic of this order of service seems to be irrefutable.

Factually, the armed forces are now aiming at a total force of about 2,000,000 men. Military tables of organization now call for 3.6 medical officers per 1,000 men, or a total of 7,200 physicians for this force. A recent call for the voluntary enrollment of 3,000 medical officers brought forth only 200 volunteers.

The medical profession was signally honored in World War II in being permitted more or less to write its own ticket. Through Procurement & Assignment Service it was allowed to divide up its own resources for the good of the nation, and it is pretty

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California Medical Association

Revised Proposed Constitution Submitted by Reference Committee No. 3, April 30, 1950

Herewith is printed, for the first time in CALIFORNIA MEDICINE, the proposed C.M.A. Constitution introduced in the 1950 House of Delegates by Reference Committee No. 3 of that body. A second printing, in accordance with existing constitutional provisions, will be made prior to the convening of the 1951 House of Delegates in regular session.

Included in this document is an additional proposed section introduced by Reference Committee No. 3 as an addendum to its original introduction of the proposed Constitution.

Members of the Association, and especially members of the House of Delegates, are urged to give this proposed Constitution a thorough study. It contains various provisions which are different from existing constitutional provisions and which have been under discussion in the House of Delegates in the past.

CONSTITUTION

ARTICLE I.—NAME, PURPOSES AND ORGANIZATION

Section 1.—Name

The name of this organization is California Medical Association (hereinafter referred to as the Association).

Section 2.—Purposes

The purposes of this Association are to promote the science and art of medicine, the protection of public health, and the betterment of the medical profession; to promote similar interests of its component societies; and to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

Section 3.—Organization

This Association has two divisions: One, the Association as an organization; and Two, the Scientific Assembly. The Association as an organization

includes component societies and their active members, the House of Delegates, Council, Commissions and Standing Committees. The Scientific Assembly includes all members of the Association and the scientific sections.

Section 4.—Definition of Component Societies

Component societies include all county medical societies (which may cover one or more counties) heretofore or hereafter chartered by this Association.

Section 5.—Component Society Charters

Charters to component societies may be granted and revoked as hereinafter prescribed, subject to the limitation that only one charter may be outstanding at any one time in any county.

ARTICLE II.—MEMBERSHIP

Section 1.—Classes of Members

The members of this Association shall consist of Active, Associate, Honorary, Retired, Life and Affiliate members.

Section 2.—Membership Qualifications, Rights, Privileges, Duties and Method of Election

The qualifications, rights, privileges, duties, obligations and methods of election of the several classes of membership are as stated in the By-Laws.

ARTICLE III.—GOVERNMENT OF THE ASSOCIATION

Part A.—House of Delegates

Section 1.—Composition

The House of Delegates shall consist of:

- (a) Delegates elected by the members of component societies;
- (b) Officers of the Association as hereinafter provided;
- (c) Ex officio, with the right to vote, the District Councilors, and
- (d) Ex officio, without the right to vote, the Past Presidents.